STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185336	A. BUILDING _____ B. WING _____	C 09/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD NURSING & REHABILITATION CENTER	420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey related to ARO KY00014940 and ARO KY00015264 was conducted on 09/07/10-09/10/10. A Life Safety Code Survey was conducted 09/09/10. Deficiencies were cited, with the highest scope and severity of a "F". ARO KY00014940 and ARO KY00015264 were found to be unsubstantiated with no deficiencies cited.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written compliance with Federal Medicare Requirements.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure residents were provided an ongoing program of activities for one (1) of fifteen (15) sampled residents (Resident #4). Resident #4 was assessed by the facility to need "mind stimulation activities" which included the use of music. However, the facility failed to ensure the resident's music machine was in use. The findings include: 1. Resident #4 was admitted to the facility with diagnoses which included Dementia, Aphasia and Mental Retardation. Review of the Quarterly Minimum Data Set (MDS), dated 06/28/10, revealed the facility assessed the resident	F 248	F248 Step 1: Resident # 4's sound machine was observed to be in use on September 24, 2010 by Director of Nursing.	

RECEIVED
OCT 14 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	10/14/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 cognitive skills for decision making as being severely impaired. The Comprehensive Plan of Care, updated 07/01/10, revealed the resident's activities participation was limited and needed "mind stimulation activities". Interventions included the resident would participate in three, one to one activities; such as sensory, talking and/or singing. The Plan of Care also indicated staff were to offer activities as preferred and music checked on the plan. Observations from 09/08/10 at 2:45 PM and 4:05 PM revealed a sound machine at Resident #4's bedside was not plugged into a power source. Observation on 09/09/10 at 8:45 AM, 10:00 AM, 12:00 Noon, 2:30 PM, 3:30 PM and 5:00 PM revealed the sound machine remained unplugged. Observation on 09/10/10 at 9:40 AM revealed the sound machine was no longer located at the resident's bedside. During the observations noted above no one on one activities were observed. Interview with the Activity Director on 09/10/10 at 10:10 AM revealed she read, played music and/or provided sensory stimulation for Resident #4. She was unaware of the use of the sound machine. Interview with Registered Nurse (RN) #5 and Licensed Practical Nurse (LPN) #12 on 09/10/10 at 2:20 PM revealed they were aware of the sound machine but did not know why it was not being used. Observation on 09/10/10 at 2:25 PM revealed the Social Services Director (SSD) found the sound	F 248	Step 2: A 100% audit of all resident activities preferences and Care Plans was conducted on September 23,2010 by a Certified Activities Professional and The Activities Director to assure activity interventions and Care Plans were in place to meet the needs of the residents. Any Care Plans or interventions found not to be in place were implemented. Step 3: The Life Enrichment Director (Activities) was educated by the Administrator on September 24, 2010 on development and implementation of activities for residents to meet the individual needs of each resident and development of an individualized Care Plan based on the resident's preferences. Step 4: The Administrator will audit five resident records per week for twelve weeks to assure Care Plans are in use and being followed and that the careplans reflect the preferences, and meet the needs of the resident. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The	

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F 248	Continued From page 2 machine in a drawer in Resident #4's room. Further observation at 3:30 PM, that same day, revealed the sound machine was plugged in and working.	F 248	Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure physician's orders followed related for two (2) of fifteen (15) sampled residents (Resident #8 and Resident #10) had orders for oxygen and oxygen saturation monitoring that were not followed. Resident #8 was ordered oxygen at two (2) liters of oxygen per minute to maintain an oxygen saturation greater than ninety (90) percent however, Resident #8 never received the oxygen. Resident #9 was ordered oxygen saturation levels to be monitored every shift and as needed, the order was never implemented. The findings include: 1. Resident #8 was admitted to the facility with diagnoses which included Head Injury, Chronic Obstructive Pulmonary Disease (COPD), and Seizures. Review of the Annul Minimum Data Set (MDS) revealed the facility assessed the resident as having long-term memory deficits and as having moderately impaired cognitive skills for daily decision making. Review of the clinical record revealed, Resident	F 281 F281	Step 1: The Physician was consulted and the Physician discontinued oxygen for Resident #8 September 10, 2010. The Physician was consulted and the Physician discontinued oxygen for Resident #10 on September 13, 2010. Step 2: A 100% audit of all physician orders for the past thirty days will be Completed by The Director of Nursing, The Assistant Director of Nursing, The Education and Training Director, and The Registered Nurse Supervisor by October 18, 2010 to assure all orders are being followed. Any orders identified as not being followed will be reviewed by the Physician for further recommendations. Step 3: All licensed staff will be educated by October 18, 2010 by Director of Nursing or the Education and Training Director on following physician orders as written. Step 4: The Director of Nursing and the Assistant Director of Nursing will conduct an audit of	10/25/2010

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F 281	Continued From page 3 #8 was discharged from the hospital on 07/01/10 with a diagnosis that included Pneumonia. Review of the hospital discharge record indicated Resident #8 was to be administered oxygen at two (2) liter per minute to maintain a saturation level greater than ninety (90) percent. Review of the admission records for Resident #8 on 07/01/10 revealed, the oxygen was never ordered and the oxygen saturation level was never monitored to ensure the resident maintain a saturation level greater than ninety (90) percent. Interview with the Director of Nursing (DON) on 09/10/10 at 10:20 AM revealed, it was a transcription error and the oxygen saturation levels had never been monitored. 2. Resident # 10 was admitted to the facility on 07/31/10 with diagnoses which included Fractures of Ribs, Carcinoma of Sigmoid Colon, Hypertension, Diabetes Mellitis, Anemia and Anxiety. Review of the Admission Minimum Data Set (MDS), dated 08/16/10, revealed the facility assessed Resident #10 as having no long-term memory deficits and having independent cognitive skills for daily decision making. Review of admission orders for the facility dated 07/31/10 revealed, oxygen saturation levels were ordered every shift. However, review of the Medication Administration Record (MAR) revealed the oxygen saturation levels were to be obtained every week and as needed. Therefore, the resident's Physician's order was not transcribed correctly. Interview with the Director of Nursing (DON), on 09/10/10, at 10:20 AM revealed , it was a transcription error and the oxygen saturation	F 281	five resident records per week for 12 weeks to ensure physician orders are followed. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010

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F 281	Continued From page 4 levels were never monitored.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was implemented for two (2) of fifteen (15) sampled residents (Resident #4 and #13). Resident #4's Plan of Care included an intervention related to the use of music, for mind stimulation, however, this this was not observed to have occurred. Resident #13's Plan of Care was noted to have an intervention that the resident's heels would have pillows to elevate his/her heels off the bed, however this was not observed to have occurred. The findings include: 1. Resident #13 was admitted with diagnoses which included Diabetes Type II, Atrial Fibrillation, Congestive Heart Failure, and Dementia. Review of Skin Integrity Plan of Care revealed Resident #13's Braden risk assessment was 15-18, which indicated the resident was at risk for the development of skin breakdown. An intervention was identified, on the Plan of Care that the resident's heels would be protected by the use of pillows to elevate his/her heels off the bed.	F 282	Step 1: The Sound machine for Resident #4 was observed to be active on September 24, 2010 by The Director of Nursing. Resident #13 was found to have feet elevated on September 24, 2010 by The Director of Nursing. Step 2: A 100% audit of Care Plans and Certified Nurse Aide work sheets will be completed by The Director of Nursing, The Assistant Director of Nursing, The Education and Training Director and The Registered Nurse Supervisor by October 18, 2010 to assure that Care Plans and interventions are communicated and interventions are in place. Step 3: All direct care staff will be re-educated on implementation of he Care Plans per Certified Nurse Aide Assignment sheets by The Director of Nursing and The Education and Training Director by October 18,2010. Step 4: The Department Heads will audit Certified Nurse Aide assignment sheets daily for 2 weeks, 5 days per week for 2 weeks and then weekly for 8 weeks to assure that interventions are in place. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any	

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F 282	Continued From page 5 Review of Physicians' Orders for September 2010 revealed an order to floated the resident's heels off the bed with pillows, at all times. Observations on 09/09/10 at 11:30 AM, 2:00 PM, 3:00 PM, 3:50 PM, and 5:00 PM revealed Resident #13's heels were not elevated. Observations on 09/10/10 at 8:50 AM, 9:20 AM, 10:00 AM, 11:00 AM, 11:30 AM and 2:00 PM, revealed the resident's hells were not elevated off bed, per the Plan of Care. Interview with CNA #9 on 09/09/10 at 4:05 PM revealed he/she followed the CNA care plan by making sure Resident #13's feet was elevated off the bed. 2. Resident #4 was admitted to the facility with diagnoses which included Dementia, Aphasia and Mental Retardation. The Quarterly Minimum Data Set (MDS), dated 06/28/10, was reviewed and revealed the facility had assessed Resident #4's cognitive skills for decision making as severely impaired. Review of the Comprehensive Plan of Care, updated 07/01/10, revealed the facility had noted the resident's activities participation was limited and needed "mind stimulation activities". An interventions on the Plan of Care indicated Resident #4 would participate in three, one to one activities, such as sensory, talking and/or singing. The Plan of Care also noted staff were to offer activities as preferred and music was checked on the plan. Observations from 09/08/10 at 2:45 PM and 4:05 PM revealed a sound machine at Resident #4's	F 282	concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010

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F 282	Continued From page 6 bedside was not plugged into a power source. Observation on 09/09/10 at 8:45 AM, 10:00 AM, 12:00 Noon, 2:30 PM, 3:30 PM and 5:00 PM revealed the sound machine remained unplugged. Observation on 09/10/10 at 9:40 AM revealed the sound machine was no longer located at the resident's bedside. On 09/10/10 at 2:25 PM the Social Services Director (SSD) found the sound machine in a drawer in Resident #4's room. Interview with Registered Nurse (RN) #5 and Licensed Practical Nurse (LPN) #12 on 09/10/10 at 2:20 PM revealed they were aware of the sound machine but did not know why it was not being used.	F 282		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed	F 353	Step 1: Resident # 4 received a shower on 9/10 and continues to receive them per Care Plan, Resident # 5 received a shower on 9/11 and continues to receive them per Care Plan, Resident #6 received a shower on 9/13 and continues to receive them per Care Plan, Resident # 10 received a shower on 9/9 and continues to receive them per Care Plan, Resident # 11 received a shower on 9/11 and continues to receive them per Care Plan, Resident # 12 received a shower on 9/9 and continues to receive them per Care Plan, Resident # 13 received a shower on 9/11 and continues to receive them per Care Plan, Resident # 14 is no longer in the center.	

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F 353	Continued From page 7 nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical and psychosocial well-being of each resident as evidenced by nine (9) of fifteen (15) sampled residents (Resident's # 4, 5, 6, 10, 11, 12, 13, 14) failed to receive showers in accordance with the facility's shower list. The findings include: Review of the facility's shower list revealed, each resident was to receive a shower at least twice a week unless otherwise indicated. The shower list revealed, Resident #11 was to receive a shower three (3) times a week on Tuesday, Thursday and Saturday. Review of the Bath Type Detail Report dated 09/08/10 revealed, Resident #11 only received a shower three (3) times during an eight week period. One week, 08/29/10 to 09/04/10, the resident was not showered at all. Review of Resident #5's shower schedule dated 09/09/10 revealed the resident was to receive a shower two (2) times per week on Mondays and Thursdays. Review of the Bath Type Detail Report for July 11, 2010 through September 09, 2010 revealed the facility only provided this resident with a shower on July 14th, 24th, 31st, August 8th, 11th and 21st, September 1st and 4th. Interview on 09/08/10 at 3:35 PM with the resident's spouse revealed the facility failed to	F 353	Step 2: The Interdisciplinary Team consisting of The Director of Nursing, The Nutritional Services Manager, The Social Service Director, The Rehabilitation Coordinator, and the Life Enrichment Director (Activities) will review resident acuity levels by October 18, 2010 to assure staff responsibilities are distributed equally to meet the needs of the residents. In addition a 100% audit of resident shower documentation will be completed by October 8, 2010 to assure residents received their showers per Care Plan and resident preferences. We will assure that any resident identified not having a shower will have a shower. Step 3: All direct care staff will be reeducated by October 18, 2010 by The Director of Nursing and The Education and Training Director on reporting to the charge nurse when their job cannot be completed. The licensed staff will be re-educated on reporting to the Director of Nursing if care needs can not be met . The Director of Nursing and the Administrator will provide additional assistance to assure the needs of the residents are met.	

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F 353	Continued From page 8 provide showers. Further interview revealed the response the facility gave to the spouse regarding those complaints was "They don't have enough staff today". Review of Resident #10's shower schedule dated 09/09/10 revealed the resident was to receive a shower two times a week on Mondays and Thursdays. The record revealed Resident #10 only received a shower one time a week from admission, on 07/31/10, until 09/09/10, with no showers provided for the weeks of 08/05/10 and 08/30/10. Interview on 09/10/10 at 2:30 PM with Resident #10's daughter revealed the facility did not have enough help and the facility was understaffed. Review of Resident #6's shower schedule dated 09/09/10 revealed the resident was to receive a shower two times a week on Mondays and Thursdays. The record revealed Resident #6 only received a shower one time a week for seven (7) weeks, which included 07/19/10 through 09/06/10. However, further record revealed the resident received no showers for the weeks of 07/12/10 and 08/30/10. Review of Resident #4's shower schedule dated 09/09/10 revealed the resident was to receive a shower two times a week on Tuesdays and Fridays. The record revealed Resident #4 only received one shower from 07/12/10 to 09/09/10, the date the shower was given was 08/07/10. Review of Resident #13's shower schedule dated 09/09/10 revealed the resident was to receive a shower two times a week on Wednesdays and Saturdays. The record revealed Resident #13	F 353	Step 4: The Director of Nursing and The Assistant Director of Nursing will audit bath detail reports five times per week for 12 weeks to assure showers are given per Care Plan. The Administrator will interview five residents per week and five family members per week to assure proper care is being provided to meet the needs of the residents. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010

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F 353	Continued From page 9 received one shower a week from 07/12/10 to 09/09/10. Interview with Resident #13 on 09/09/10 at 12:00 PM revealed he/she only received one shower a week most times, related to the facility just didn't have enough help. Review of Resident #12's shower schedule dated 09/09/10 revealed the resident was to receive a shower two times a week on Mondays and Thursdays. The record revealed Resident #12 received a shower on the following dates, 07/12/10, 07/22/10, 08/26/10, 09/03/10 and 09/06/10. Per review of the shower schedule no showers were provided for the following weeks, 07/26/10, 08/02/10, 08/09/10, 08/16/10. Interview with CNA #7 on 09/09/10 at 2:10 PM revealed that on non-shower days the residents were to receive a bed baths and the aides notified the Charge Nurse when off of floor giving a shower. Further interview revealed this SRNA had twelve residents on a daily basis and today (09/09/10). The SRNA indicated that five out of the twelve residents were to receive showers and eight of these residents require two for transfers. This SRNA stated that ten of the residents required turned and repositioned every two hours and voiced there was not enough time to get it all finished. Interview with CNA #12 on 09/09/10 at 1:15 PM revealed the this CNA was assigned to provide care for twelve residents. CNA #1 stated six of these twelve required to be turned and repositioned every two hours, nine residents were incontinent of bowel and bladder and two residents required assistance with feeding. The	F 353		

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F 353	Continued From page 10 aide indicated three of these residents required the assistance of two staff for a bed bath and three residents were to have showers, that day (09/09/10). CNA #12 stated that all twelve residents required two staff to assist with transfers. CNA #12 revealed "I can't always get it all finished" especially when we only have two aids working. This CNA stated "I report what I don't get finished to the Charge Nurse and she reports to the Director of Nursing". Interview on 09/09/10 at 2:00 PM with CNA #4 revealed the residents did not receive showers when needed because the facility was so short-staffed. Interview with CNA #8 on 09/09/10 at 2:05 PM revealed, the CNA was not able to accomplish tasks for the scheduled shift and "they always want you to do something else". CNA #8 also revealed, incomplete tasks were reported to the Charge Nurse who then reported to the Director of Nursing (DON). Interview with the Charge Nurse/Registered Nurse (RN) #5 on 09/09/10 at 3:10 PM revealed aides went to the Charge Nurse if falling behind in daily tasks. Further interview revealed the Charge Nurse would then notify the Director of Nursing or Staff Development of staffs inability to finish work on time. Interview with the DON on 09/10/10 at 10:25 AM revealed, staff do not report to the DON, CNAs report work not done to their nurse. The DON indicated nurses do not notify her of work not completed, such as showers. The DON stated she ran a report every morning, Monday through Friday, to monitor that showers and baths are	F 353		

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	185336	A. BUILDING _____ B. WING _____	C 09/10/2010

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F 353	Continued From page 11 completed. The DON stated, "I have been working on a plan to correct this problem".	F 353		
F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	Step 1: A sign was placed outside the door on the room of resident #3 directing visitors to see the nurse before entering on September 8, 2010. Step 2: A 100% audit of resident records will be completed by October 8, 2010 by The Director of Nursing and The Assistant Director of Nursing to assure any resident who has an infectious disease is placed in appropriate precautions and that precautions are in place. Step 3: Education of all direct care staff will be completed by October18, 2010 by The Education and Training Director on contact precautions. Step 4: An audit of five resident records per week for twelve weeks, with an active infection if available, will be completed by The Director of Nursing, The Assistant Director of Nursing, The Education and Training Director and The Registered Nurse Supervisor to assure appropriate infection control practices were identified and implemented. The Director of Nursing will observe five staff members per week for twelve weeks to assure they are utilizing appropriate precautions as indicated, and to assure appropriate Infection Control	

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F 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain an infection control program to help prevent the development and transmission of disease and infection for one (1) of fifteen (15) sampled residents (Resident #3). Resident #3 was diagnosed with Clostridium Difficile. However, the facility failed to ensure visitors and residents were aware of the importance of hand hygiene and failed to ensure staff implemented the facility's policy related to hand washing and donning gloves, when needed. The findings include: Review of the facility's Infection Control Policy (updated November 2008) revealed to "Advise families, visitors, and residents about the importance of hand hygiene to minimize the spread of fecal contamination to surfaces." The policy stated "Wear clean, non-sterile gloves when entering the room of a C-dif infected resident" and "If no contact with the resident, environmental surfaces, or items in the room is anticipated, gowns are not necessary". The facility's policy also included staff were to "Remove gloves and gowns before leaving the resident room and wash hands immediately with plain soap". Review of Resident #3's clinical record revealed diagnoses which included Aphasia, Diabetes and Dysphagia. Review of the Quartey Minimum Data Set (MDS), dated 07/27/10, revealed the facility	F 441	Standards are in place and staff are observed to be following. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010

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F 441	Continued From page 13 assessed the resident as being incontinent of bowel and bladder. Review of Resident #3's clinical record revealed the resident was discharged from the hospital on 08/30/10 with diagnoses which included Clostridium-Difficile (C-Diff), Urinary Tract Infection (UTI) and Methicillin-Resistant Staphylococcus (MRSA) of the nares. Review of the Physician orders revealed the resident was order Vancomycin 125mg (an antibiotic), to be provided three times a day. Observation revealed, the facility had no signage related to the how visitors, family and/or residents would have knowledge related to the need for hand hygiene. However, on 09/08/10 the facility placed a sign, on the resident's doorway, which indicated to see the nurse before entering the resident's room. On 09/09/10 at 9:15 AM RN #6 was observed to enter Resident #3's room without donning a gown or gloves. The RN was observed to move the resident's bedside tables closer to the resident, with bare hands. RN #6 exited Resident #3's room without washing his/her hands. Interview on 09/10/10 at 10:00 AM with RN #6 revealed she should have put on a gown and gloves before she entered the resident's room and should have washed her hands before leaving the resident's room. Interview on 09/09/10 at 9:45 AM with the Director of Nursing (DON) revealed the nurse should have put a gown and gloves on before she entered the resident's room.	F 441		
F 514	483.75(l)(1) RES	F 514		

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F 514 SS=D	Continued From page 14 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented as evidenced by two (2) of fifteen (15) sampled residents (Resident #8 and Resident #10) had incorrect transcription of the physician's orders. Resident #8's oxygen and oxygen saturation monitoring was transcribed to the Medication Administration Record (MAR) incorrectly. Resident #10's oxygen saturation monitoring order, on admission, was to monitor every shift instead of every week as needed. The findings include: Review of Resident #8's clinical record revealed diagnoses which included Head Injury, Chronic Obstructive Pulmonary Disease (COPD), and	F 514	Step 1: The Physician was consulted and The Physician discontinued oxygen for Resident #8 September 10, 2010. The Physician was consulted and The Physician discontinued oxygen for Resident #10 on September 13, 2010. Step 2: A 100% audit will be completed by The Director of Nursing, The Assistant Director of Nursing, The Education and Training Director and The Registered Nurse Supervisor to assure all physician orders in the past thirty days were transcribed correctly, as well as to assure that all medical records are complete, accurately documented, readily accessible and systematically organized by October 22, 2010. Any identified issues will be corrected. Set 3: All Licensed Staff will be re-educated on the proper procedure to transcribe new physician orders onto Medication Administration Records and Treatment	

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F 514	Continued From page 15 Seizures. Review of the Annul Minimum Data Set (MDS) revealed the facility assessed Resident #8 as having long-term memory deficits and moderately impaired cognitive skills for daily decision making. Review of the Discharge orders from the hospital, dated 07/01/10, revealed Resident #8 was to have oxygen at two (2) liters per minute via nasal cannula and oxygen saturations were to be maintained greater than ninety (90) percent. Review of the Readmission orders for the facility dated 07/01/10 revealed, oxygen saturation levels were ordered every shift and as needed with an oxygen saturation level every week after having been off the oxygen for twenty (20) minutes. Not only were these orders never written, they were not followed, as well. Interview with the Director of Nursing (DON) on 09/10/10 at 10:20 AM revealed, it was a transcription error and the oxygen saturation levels had never been monitored. Resident #10 was admitted to the facility on 07/32/10 with diagnoses which included Fractures of Ribs, Carcinoma of Sigmoid Colon, Rehabilitation Process, Hypertension, Diabetes Mellitis, Anemia and Anxiety. Review of the Admission Minimum Data Set (MDS) revealed,the facility assessed Resident #10 as having no long-term memory deficits and independent cognitive skills for daily decision making. Review of admission orders for the facility dated 07/31/10 revealed, oxygen saturation levels were ordered every shift, the order was written for every week and as needed. This order was transcribed incorrectly and not followed per	F 514	Administration Records as well as to assure that all medical records are complete, accurately documented, readily accessible and systematically organized by October 22, 2010. Step 4: The Director of Nursing or The Assistant Director of Nursing will audit five resident records per week to assure that all medical records are complete, accurately documented, readily accessible and systematically organized for twelve weeks and fifteen monthly physician orders each month for three months to assure correct transcription of Physician orders. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance	

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F 514	Continued From page 16 physicians orders. Interview with the Director of Nursing (DON), on 09/10/10, at 10:20 AM revealed , It was transcription error and the oxygen saturation levels were never monitored.	F 514	Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 09/09/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".	K 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written compliance with Federal Medicare Requirements.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors located in smoke barriers were an approved type according to NFPA standards. The findings include: Observation on 09/09/2010 at 10:52 AM, revealed three (3) access doors located in the attic smoke barriers were not of an approved type. The observation was confirmed with the Maintenance Director. These doors must be of an approved type to limit the spread of smoke or fire.	K 025	Step 1: Approved smoke doors will be installed in the areas noted in the attic by October 25, 2010. by The Maintenance Director.	

RECEIVED
OCT 14 2010
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR | 10-14-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Interview on 09/09/2010 at 10:52 AM, with the Maintenance Director, revealed the doors had never been identified as a deficiency in the past. Reference: NFPA 101 (2000 Edition). 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (3) 1/2-hour fire barrier - 20-minute fire protection rating (1) 2-hour fire barrier - 11/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42	K 025	Step 2: A 100 % audit of smoke doors and barriers will be completed by October 1, 2010 by The Administrator and The Maintenance Director. Any identified areas will be corrected. Step 3: The Maintenance Director will be re-educated on October 1, 2010 by The Administrator on the requirements of smoke barrier doors. Step 4: The Maintenance Director will check all smoke doors and barriers each week for 12 weeks. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensue fire extinguishers were maintain according to NFPA codes. The findings include:	K 069 K069	Step 1: A sign will be posted by The Maintenance Director by October 6, 2010 indicating that the fire extinguisher is a K type fire extinguisher. Step 2: A 100% Audit will be conducted on all fire extinguishers by The Administrator and The Maintenance Director by	

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K 069	Continued From page 2 Observation on 09/09/2010 at 11:07 AM, revealed that the "K" type fire extinguisher located in the kitchen area failed to have the required signage. The observation was confirmed with the Maintenance Director. Fire extinguishers must have the proper signage in order for staff to be aware of the fire extinguishers proper use. Interview on 09/09/2010 at 11:07 AM, with the Maintenance Director, reveals he was unaware of the missing sign for the "K" type fire extinguisher. Reference: NFPA 96 (1999 edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.	K 069	October 1, 2010. If any signage is noted to be missing The Maintenance Director will install the proper signage. Step 3: The Administrator will ~~reeducate The Maintenance~~ Director on Fire Extinguisher labeling requirements by October 1, 2010. Step 4: The Maintenance Director will check fire extinguishers monthly for three months to assure all fire extinguishers have appropriate signage. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions to full instant use, in the case of fire or other emergency, according to NFPA standards.	K 072 K072	The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed. Step 1: Three (3) medicine carts and two (2) patient lifts were removed from the hall by The Administrator and The Maintenance Director on September 27,2010. Step 2: The Administrator observed on September 28, 2010 that the hallways were	10/25/2010

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K 072	Continued From page 3 The findings include: Observation on 09/09/2010 at 11:13 AM, revealed in the East Wing Corridor there were three (3) medicine carts and two (2) patient lifts found unattended and not in use. Further observation on the West Wing Corridor, revealed there were three (3) medicine carts and two (2) patient lifts found to be unattended and not in use. The observations were confirmed with the Maintenance Director. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the hand rails by occupants of the building when needed. Interview on 09/09/2010 at 11:13 AM, with the Maintenance Director, revealed he was unaware that the carts and lifts could not be left in the hallways.	K 072	cleared of equipment to allow egress. Step 3: All staff will be reeducated on proper placement and storage of equipment to allow egress from the facility by October 25, 2010 by The Education and Training Director. Step 4: The Department Heads will monitor three times per day for three weeks then weekly for nine weeks. Results of the audits will be reviewed with the Quality Assurance Committee monthly for three months. If any concerns are identified during audits, a Quality Assurance meeting will be convened to determine further interventions. The Quality assurance committee will consist of at a minimum The Administrator, The Director of Nursing, The Maintenance Director and The Housekeeping Director. The Medical Director will participate quarterly and as needed.	10/25/2010